OCCUPATIONAL/PHYSICAL THERAPY - SPEECH PATHOLOGY
PRIOR APPROVAL - REQUEST/AUTHORIZATION

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

1. CONTROL NUMBER

NOTE: FOR INITIAL AND REVISED REPORTS ONLY, YOU MUST ATTACH COPY OF INITIAL EVALUATION AND TREATMENT PLAN.

CONSULTANT USE ONLY

2. | 3. | 4.

5. PRIOR AUTHORIZATION NUMBER

6. TREATMENT SITE	7. TYPE	8. I.D. NUMBER	9. PROVIDER'S USE ONLY

10. ADDRESS (NUMBER, STREET, CITY, STATE, ZIP)	11. PHONE NUMBER

12. RECIPIENT NAME (LAST, FIRST, MIDDLE INITIAL)	13. SEX	14. I.D. NUMBER	15. BIRTHDATE	16. ADM. DATE

17. DIAGNOSIS TO BE TREATED/EVALUATED	18. ONSET DATE

19. THERAPIST/PATHOLOGIST NAME (LAST, FIRST, MIDDLE INITIAL)	20. OFFICE PHONE NUMBER	21. LICENSE/CERTIFICATION NUMBER

22. TREATMENT AUTHORIZATION REQUEST ☐ INITIAL ☐ CONTINUING ☐ REVISED	23. SERVICE GIVEN BY THERAPIST/ ☐ PATHOLOGIST ☐ ASST. ☐ AIDE	24. TREATMT. MO.	25. DATE STARTED	26. LAST AUTH.	27. NO. SESSIONS

28. REHABILITATION POTENTIAL

33. GOALS

ESTIMATED TIME

34. PROGRESS NOTE/DISCHARGE PLAN

29. LINE NO.	30. NUMBER PER MONTH	31. PROCEDURE CODE	32. CONSULTANT USE ONLY
01			
02			
03			
04			
05			
06			

35. COMPLICATIONS CAUSING EXTENSION OF TREATMENT

36. PHYSICIAN CERTIFICATION

I certify _____, re-certify _____ that I have examined the patient and determined that therapy is necessary; that service will be furnished on an in/out-patient basis while the patient is under my care; that I approve the above treatment plan or evaluation and will review it every 30 days or more often if the patient's condition requires.

PHYSICIAN NAME (TYPE OR PRINT) | PHYSICIAN SIGNATURE | DATE

37. PROVIDER CERTIFICATION

The patient named above (parent or guardian if applicable) understand the necessity to request prior approval for the services indicated. I understand that services requested herein require prior approval and if approved and submitted on the appropriate invoice, payment and satisfaction of approved services will be from Federal and State funds. I understand that any false claims, statements or documents or concealment of a material fact may lead to prosecution under applicable Federal or State law.

PROVIDER SIGNATURE | DATE

CONSULTANT USE ONLY

38. CONSULTANT REMARKS

39. APPROVED AS PRESENTED ☐ AMENDED ☐	40. DISAPPROVED ☐	41. CONSULTANT SIGNATURE	42. DATE	43. MONTH

MSA-115 (Rev. 9-96) Previous edition may be used.